# Section 6. Appendices

# 6. Appendices

## *Additional Information & Resources*

The materials in these appendices are definitions and resources that you may find useful as your institution works to improve maternity care. Appendix A contains common data and performance measure definitions being used by various professional, government, payer and quality organizations. Included in this section are the applicable draft definitions from the reVITALize project which aims to standardize data definitions in maternity care across all data users. The final definitions are expected to be released in mid-2013. Appendix B is the Washington Perinatal Quality Improvement Survey which was administered in late 2012 and will be repeated periodically to track the policies and practices of birth facilities in the state. The 2012 survey report will be posted on the Washington State Perinatal Collaborative website (www.waperinatal.org) in mid-2013.

Many different groups issue definitions for data elements and quality or performance measures. These groups include government, insurers, quality organizations, and others. This appendix is not a comprehensive catalog of organizations and their data definitions, but highlights several key data definitions.

## The Joint Commission

The Joint Commission Perinatal Care (PC) set of measures includes the following five measures:

- PC-01 Elective Delivery
- PC-02 Cesarean Section
- PC-03 Antenatal Steroids
- PC-04 Health Care-Associated Bloodstream Infections in Newborns
- PC-05 Exclusive Breast Milk Feeding

All hospitals, beginning in 2014, must submit National Quality Forum (NQF) measure #0469 (*The Joint Commission Perinatal Care PC-01*) Elective Delivery Measure to the Centers for Medicare and Medicaid Services (CMS) as part of the Hospital Inpatient Quality Reporting (IQR) Program. All hospitals with 1,100 or more births will also be required to submit the entire Perinatal Care (PC) Measure Set to the Joint Commission for accreditation. The Joint Commission requires this entire set because of the high volume of births in the U.S. and because most hospitals provide maternity care services. The Joint Commission expects that the 1,100 birth threshold will be lowered over time to include more hospitals. It also encourages hospitals to consider adopting this measure set before the required effective date of January 1, 2014.

Additional information on the Joint Commission Perinatal Care definitions can be found in the ***Specifications Manual for Joint Commission National Quality Measures***.

## New CMS 2013 Data Submission Requirements

All hospitals in Washington State received the information on the following page regarding mandatory collection and reporting of early elective deliveries to CMS from the Washington State Hospital Association. As of the beginning of 2013, hospitals (that are not critical access hospitals) are required to submit these data to CMS, and beginning in 2015 hospitals will receive pay for reporting incentives.
The letter also contained additional resources and links, including:

***Information for CMS Hospital IQR Program***, the Specifications Manual and optional paper-based PC-01 data collection form.

***Joint Commission 2013A1 PC-01 definition***

***Joint Commission Appendix A*** (including Table 11.07 – Conditions Possibly Justifying Delivery Prior to 39 Completed Weeks), 2013A1 version.

Dear Perinatal Nurse Managers,

We wanted to give you information regarding a new CMS 2013 data submission requirement for Elective Delivery < 39 weeks. The Washington State Hospital Association will also be including this information in their upcoming electronic Partnership for Patients Newsletter, which goes to a broad list of hospital administrators and quality improvement leaders.

Beginning with 1/1/2013 maternal discharges, all non- critical access hospitals will be required to report performance to CMS QualNet on **PC-01: Elective Early-Term Delivery**

- PC-01 Elective Delivery is being added to the list of Inpatient Quality Reporting (IQR) metrics
- CMS requirement will follow the PC-01 Joint Commission measure definition and specifications version in effect for the maternal discharge date (v2013A1 starting January 1, 2013)
- Pay-For-Reporting determination will begin with Federal Fiscal Year 2015

Current rules state that the numerator, denominator, exclusion counts and total population per hospital must be entered into Quality Net similar to other structural measures. Data submitted will be aggregate only rather than individual patient-level data.

- CMS will allow sampling according to Joint Commission specifications
- Data elements required for submission to CMS include:
  - Total population: maternal delivering patients between 8-64 years of age with a length of stay <=120 days
  - Denominator: patients with deliveries >=37 and < 39 weeks of gestation and no exclusions
  - Numerator: patients with inductions and cesarean deliveries not in labor and not experiencing spontaneous rupture of membranes
  - Exclusions in four categories: determined in order of Joint Commission abstraction skip logic:
    1) ICD-9-CM diagnosis code on exclusion list (Table 11.07 of JC Appendix A)
    2) Enrolled in OB randomized clinical trial
    3) Prior uterine surgery or uterine injury (see JC for specific definitions)
    4) Gestational age at delivery 37 to < 39 weeks gestation
- Sampling method selected by hospital: Quarterly, Monthly, No Sampling
  - Hospitals are to submit data quarterly, with submission windows and deadlines similar to other Core Measures
  - Jan-Mar, 2013 discharges will be due by July 1 to Aug 15, 2013
  - Apr-June, 2013 discharges will be due by Oct 1 to Nov 15, 2013
  - July-Sep 2013 discharges will be due by Jan 1 to Feb 15, 2014
  - Oct-Dec 2013 discharges will be due by Apr 1 to May 15, 2014

**CMS PC-01 Elective Delivery Data Collection Recommendations for Hospitals:**

If your hospital already has a Joint Commission Core Measure vendor, which includes support for the Perinatal Care Core Measures, we recommend using that vendor data collection system for chart abstraction and collection of final aggregate data required by CMS. This method would be the most efficient due to the complexity of data collection for the four exclusion categories in the order of Joint Commission skip logic. Because of this skip logic order, some chart abstraction will occur for deliveries in all gestational age ranges. If your hospital does not currently have a Joint Commission Core Measure vendor we recommend that you use the CMS paper-based data collection method provided by CMS Quality Net. The CMS Abstraction and Reporting Tool (CART), does not contain collection for the Perinatal Care Core Measures. This is because CMS Quality Net is only requiring hospitals to submit aggregate data at this time for PC-01 Elective Delivery rather than the patient level data, which the CART system collects.

**Recommendations regarding abstraction of medical records by Joint Commission Random Sampling vs. 100% chart abstraction to meet CMS requirements:**

For those hospitals with stable low rates per quarter of <=10%: Random Sampling per Joint Commission specifications would be most efficient for determining data needed for CMS submission.
For those hospitals with unstable rates or rates > 10%: 100% chart review is recommended in order to continue vigilant efforts to identify reasons for fall-out cases and reduce rates

**2013 Elective Delivery Data Submission for WSHA Partnership for Patients**

Because of the large increased chart abstraction burden for hospitals to meet the CMS 2013 requirements we have decided to further simplify data submission for the WSHA Partnership for Patients effort. Data elements required in 2013 for submission are:

1) Numerator
2) Denominator
3) Hospital Sampling Choice: Random Sampling or 100% Review

Washington State Hospital Association

## The National Quality Forum

The National Quality Forum (NQF) Board of Directors approved 14 quality measures on perinatal care in April 2012. The measures cover care from several maternity care areas, including childbirth, pregnancy and postpartum, and newborn care. The following is the list of NQF endorsed measures along with their sponsor organization:

- 0469: PC-01 Elective Delivery (Joint Commission)
- 0470: Incidence of Episiotomy (Christiana Care Health System)
- 0471: PC-02 Cesarean Section (Joint Commission)
- 0472: Appropriate Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision– Cesarean Section (Massachusetts General Hospital/Partners Health Care System)
- 0473: Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery (Hospital Corporation of America)
- 0475: Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Facility Discharge (Centers for Disease Control and Prevention)
- 0476: PC-03 Antenatal Steroids (Joint Commission)
- 1746: Intrapartum Antibiotic Prophylaxis for Group B Streptococcus (GBS) (Massachusetts General Hospital)
- 0477: Under 1500g Infant Not Delivered at Appropriate Level of Care (California Maternal Quality Care Collaborative)
- 0478: Neonatal Blood Stream Infection Rate (NQI #3) (Agency for Healthcare Research and Quality)
- 1731: Health Care-Associated Bloodstream Infections in Newborns (Joint Commission)
- 0304: Late Sepsis or Meningitis in Very Low Birth Weight (VLBW) Neonates (risk-adjusted) (Vermont Oxford Network)
- 0480: PC-05 Exclusive Breast Milk Feeding (Joint Commission)
- 0483: Proportion of Infants 22 to 29 Weeks Gestation Screened for Retinopathy of Prematurity (Vermont Oxford Network)

## The Obstetrics Clinical Outcomes Assessment Program

The Obstetrics Clinical Outcomes Assessment Program (OB COAP) is a clinician-led, chart-abstracted database of the intrapartum care of pregnant women in Washington State. It is one of the clinical programs of the Foundation for Health Care Quality, a nonprofit organization dedicated to providing a trusted, independent, third-party resource to all participants in the health care community – including patients, providers, payers, employers, government agencies, and public health professionals. The OB COAP database includes collection of nine of the NQF guidelines for perinatal care. As perinatal care measures change, OB COAP's flexibility allows changes to be incorporated.

## ReVITALize Obstetric Data Definitions

The reVITALize Obstetric Data Definitions Conference brought together over 80 national leaders in women's health care with the common goal of standardizing clinical obstetric data definitions for use in registries, electronic medical record systems, and vital statistics. The meeting took place in August 2012 over a two day period. During the meeting, and over the months that followed, more than 60 obstetrical definitions were reviewed, discussed, and refined. Data element categories included: delivery, gestational age and term, labor, current maternal co-morbidities and complications, and maternal historical diagnoses.

For more information, see the ***Executive Summary of the reVITALize Obstetric Data Definitions Conference.***

Comments on the proposed revised draft definitions were collected from November 15, 2012 to January 15, 2013. Comments received are being reviewed and final definitions are expected to be released in mid-2013.

# Appendix A: Data & Performance Measure Definitions

The definitions which were posted for comment are included at the end of this appendix. Each term has a proposed definition and includes additional considerations that were identified and highlighted for those who commented on them. The following are the refined definitions for the Gestational Age & Term, Labor, and Maternal Indicators categories (public comment period closed January 15, 2013).

## *Gestational Age & Term*

### Gestational Age (Formula)

Gestational age (written with both weeks and days, e.g. 39 weeks and 0 days) is calculated using the best obstetrical EDD based on the following formula: [280 days - (EDD - reference date)]/7

***Example:*** [280 days – (July 10 – July 1)]/7 = (280 – 9)/7 = 38 weeks and 5 days

*Notes: The above formula should be read as 280 days less the number of days between the EDD and reference date. The formula does not work properly when dates do not fall within the same month.*

### Estimated Date of Delivery

The best obstetrical Estimated Date of Delivery (EDD) is determined by: 1) last menstrual period (LMP) if confirmed by early ultrasound or no ultrasound performed, or 2) early ultrasound if no known LMP or the ultrasound is not consistent with LMP, or 3) known date of conception (e.g. ART, IUI)

*Notes: 1) Ultrasound margin of error and "early" to be defined by ACOG, 2) pregnancy should not be re-dated by a later ultrasound after a best obstetrical estimate of EDD has been established.*

### Preterm

Less than or equal to 36 weeks 6 days

### Early Term

37 weeks 0 days through 38 weeks 6 days

### Full Term

39 weeks 0 days through 40 weeks 6 days.

### Late Term

41 weeks 0 days through 41 weeks 6 days.

### Post Term

42 weeks 0 days and beyond.

### Labor

Uterine contractions resulting in concomitant cervical change (dilation and/or effacement). Phases: 1) Latent phase –from the onset of labor to the onset of the active phase, 2) Active phase – accelerated cervical dilation generally beginning at 5 cm for multiparous and at 6 cm for nulliparous

*Notes: 1) Avoid term "prodromal labor," 2) is either spontaneous or induced.*

### Labor After Cesarean (LAC)

Labor in a woman who has had a previous Cesarean delivery. Planned LAC occurs in a woman intending to achieve a vaginal delivery. Unplanned LAC occurs in a woman intending an elective repeat Cesarean delivery.

### Onset of Labor

The time when uterine contractions began that resulted in labor with or without the use of pharmacological and/or mechanical interventions to initiate labor.

### Augmentation of Labor

The stimulation of uterine contractions to increase their frequency and/or strength following the onset of spontaneous labor. Does not apply if the following is performed: induction of labor. Still applies even if any the following is performed: stimulation of existing uterine contractions following spontaneous ruptured membranes.

### Induction of Labor

The use of pharmacological and/or mechanical methods to initiate labor. Examples of methods include, but are not limited to: artificial rupture of membranes, balloons, oxytocin, prostglandin, laminaria, or other cervical ripening agents. Still applies even if any of the following are performed: 1) Attempts at initiating labor even if unsuccessful, 2) initiation of labor following spontaneous ruptured membranes without contractions.

### Pharmacologic Induction of Labor

Included cervical ripening agents.

### Non-Medically Indicated Induction of Labor or Cesarean Delivery

An induction performed in the absence of medical (maternal and/or fetal) indication(s).

### Number of Centimeters Dilated on Admission

The last documented cervical dilation, in centimeters, when the provider orders initiation of extended ante-partum or intra-partum care.

*Notes: 1) Cervical dilation may be unknown with: a) Preterm labor (Transvaginal cervical length or results of fetal fibronection may be sufficient for admission), B) rupture of membranes, C) vaginal bleeding; 2) Cervical assessment may be done by nurse or provider.*

### Spontaneous Onset of Labor

Labor without the use of pharmacological and/or mechanical interventions to initiate labor. Does not apply if the following is performed: artificial rupture of membranes.

*Notes: May occur at any gestational age.*

### Spontaneous Labor & Birth

Initiation of labor without the use of pharmacological and/or mechanical interventions resulting in a non-operative vaginal birth. Does not apply if any of the following are used or performed: 1) cervical ripening agents, mechanical dilators, and induction of labor, 2) episiotomy, 3) forceps or vacuum assistance, 4) Cesarean section.

*Notes: Augmentation of labor and regional anesthesia are not exclusions.*

### Physiologic Childbirth

Spontaneous labor and birth at term without the use of pharmacologic and/or mechanical interventions throughout labor and birth. Does not apply if any of the following are used or performed: 1) opiates, 2) augmentation of labor, 3) regional anesthesia except for the purpose of spontaneous laceration repair.

### Duration of Ruptured Membranes

Duration from rupture of membranes to delivery (in hours).

### Artificial Rupture of Membranes

An intervention that perforates the amniotic sac. Still applies even if the following are performed: Interventions that occur transvaginally. Does not apply if any of the following are used or performed: Invasive procedures such as amniocentesis, laser therapy.

*Notes: May first occur at Cesarean delivery.*

### Pre-Labor Rupture of Membranes

Spontaneous rupture of membranes that occurs before the onset of labor.

*Notes: Modified by gestational age categories (i.e. preterm, early term)*

### Spontaneous Rupture of Membranes

A naturally occurring rupture of the amniotic sac. Does not apply if the following is performed: artificial rupture of membranes.

*Notes: May occur at any gestational age.*

## *Maternal Indicators: Current Co-Morbidities & Complications*

### Abruption

Placental separation from the uterus with bleeding (concealed or vaginal) before fetal delivery, with or without maternal/fetal compromise. Does not apply if the following occurs: Placenta previa.

### Early Postpartum Hemorrhage

Cumulative blood loss of >=1000ml OR blood loss accompanied by sign/symptoms of hypovolemia within the first 24 hours following delivery.

*Notes: 1) Signs/symptoms of hypovolemia may include tachycardia, hypotension, tachypnea, oliguria, pallor, dizziness, or altered mental status, 2) cumulative blood loss of 500-999ml alone should trigger increased supervision and potential interventions as clinically indicated, 3) a fall in hematocrit of >10% can be supportive data but generally does not make the diagnosis of postpartum hemorrhage alone.*

### Antenatal Small for Gestational Age

Estimated fetal weight by ultrasound less than the 10th percentile for gestational age.

*Notes: While most growth-restricted fetuses are "antenatal small for gestational age," the reverse is not true. Therefore, the terms "fetal growth restriction" (FGR) and "intrauterine growth restriction" (IUGR) should not be used interchangeably with "antenatal small for gestational age." Fetal growth restriction (FGR) and intrauterine growth restriction (IUGR) should be reserved for those situations where there is additional evidence that the health of the fetus is affected. Findings that would corroborate that smallness is the result of a pathologic process, rather than a constitutional finding, include abnormal umbilical artery Doppler indices, oligohydramnios, associated maternal co-morbidity known to affect utero-placental perfusion, or an abnormal fetal growth trajectory.*

### Any Antenatal Steroids

Either full course or partial course of corticosteroids for fetal lung development. Full course: a complete course of corticosteroids given with delivery 48 hours or later from the first dose. Partial course: corticosteroid started, but full course not completed.

### Clinical Chorioamnionitis

Clinical diagnosis of chorioamnionitis during labor or after pre-labor rupture of membranes. Usually includes unexplained fever (at or above 38 degree C (100.4 F)) with one or more of the following: uterine tenderness and/or irritability, leukocytosis, fetal tachycardia, maternal tachycardia, ruptured membranes >18 hrs.

*Notes: Non-laboring, intact membranes with unexplained fever requires additional testing.*

### Depression

Refer to the most current version of DSM for definition.

## *Maternal Indicators: Historical Diagnosis*

### Chronic Hypertension

Chronic Hypertension (existing prior to pregnancy): See National Center for Health Statistics (NCHS) definition: Elevation of blood pressure above normal for age, gender, and physiological condition. Diagnosis prior to the onset of this pregnancy-does not include gestational (pregnancy induced hypertension (PIH)). Chronic Hypertension Diagnosed During Current Pregnancy: Hypertension diagnosed before the 20th week of current pregnancy.

### Pregestational Diabetes

Glucose intolerance diagnosed before current pregnancy (coordinate with GDM).

### Positive GBS Risk Status

1) Rectal vaginal culture positive within 5 weeks prior to delivery, or 2) Urine GBS culture positive* or GBS bacteria at any point in current pregnancy, or 3) Prior infant affected by GBS.

**As defined by the CDC*

### Gravida

A woman who currently is pregnant or has been in the past, irrespective of the pregnancy outcome. Gravidity: The number of pregnancies, current and past, regardless of the pregnancy outcome.

### Plurality

The number of fetuses delivered live or dead at any time in the pregnancy regardless of gestational age, or if the fetuses were delivered at different dates in the pregnancy. Does not apply if the following occurs: "Reabsorbed" fetuses (those that are not delivered: expulsed or extracted from the mother).

### Parity

The number of pregnancies delivered at 20 weeks 0 days, or beyond, regardless of the number of fetuses alive or dead.

### Nulliparous

A woman who has never completed a pregnancy beyond 20 weeks gestation (linked with parity).

### Non-Cesarean Uterine Surgery

Surgery/injury and healing of the myometrium prior to delivery other than from Cesarean delivery.

### Maternal Weight Gain During Pregnancy

The weight at delivery minus the weight immediately prior to pregnancy.

Additional definitions and updates can be found on ACOG's ***reVITALize*** website.

# Washington State Perinatal Quality Improvement Survey

In 2009, the Department of Health in collaboration with the Washington State Perinatal Advisory Group and the Washington State Hospital Association administered an online survey to delivery hospitals to learn about obstetric quality improvement and data collection practices. Results from this initial survey informed the development of the Washington State Perinatal Collaborative (WSPC) and statewide quality improvement efforts. These efforts initially focused on reducing elective deliveries before 39 weeks gestation. In 2012, the WSPC transitioned to a focus on strategies to reduce unwarranted variability in Cesarean delivery rates. The group wanted to resurvey hospitals to provide more current information to help focus efforts. The 2012 survey was completely redesigned to focus on obstetric policies and practices related to labor admission, labor management, scheduled induction of labor, scheduled Cesarean delivery, trial of labor after Cesarean birth, staffing, and training. The survey also obtained information on data collection, data sharing and benchmarking, and quality improvement efforts. It was administered online in fall 2012 and is currently being analyzed. The survey will be an ongoing part of statewide quality improvement efforts in Washington. The survey has been able to provide a picture of the landscape of policies and practices in place in Washington. The Department of Health and WSPC anticipate resurveying hospitals every few years to evaluate whether changes in education and training result in policy and practice changes, as well as whether these changes are impacting outcomes and goals.

## Survey

We want to learn about your hospital's obstetric policies and procedures to help improve perinatal care across the state. The Washington State Perinatal Advisory Committee (PAC) is conducting this survey to gather information regarding perinatal policies, data tracking and quality improvement efforts. We will use the data to develop strategies and recommendations related to perinatal quality improvement in Washington State. We hope to repeat this survey every few year to monitor changes in hospital practices.

Though this survey will not take long to complete, we strongly recommend that you first review the printable version, located here: [LINK]. It may be helpful to research and prepare your answer in advance. Please submit only one response from your hospital. This survey is voluntary but we ask that at a minimum you provide your name and hospital name so we can track who has been contacted to participate.

If you have any questions about the survey, please contact [NAME, PHONE, EMAIL].

First, please provide your name and contact information:
Name: _____
Hospital: _____
City/Town: _____
Email Address: _____
Phone Number: _____

What is your role at the hospital? If you serve multiple roles, please check the one that best characterizes your role as the respondent to this survey:
___ OB Medical Director
___ OB Charge Nurse
___ Labor & Delivery Staff Nurse
___ Hospital Quality Improvement Director
___ Hospital Medical Director
___ Other, please specify: _____

# Appendix B: WA Perinatal Quality Improvement Survey

## Section 1: Data Collection and Quality Improvement

The next few questions address the data that your hospital collects and reviews as part of its perinatal quality improvement or performance improvement efforts.

1. Do you have a perinatal dashboard or set of indicators you collect and track on a regular basis over time?
   ___ Yes
   ___ No (please go to question 7)

2. How often are these perinatal data shared with providers?
   ___ Data aren't shared with providers
   ___ Yearly
   ___ Quarterly
   ___ Other, please describe: _____

3. What indicators do you track (please check all that apply)?
   ___ Cesarean section (C-section) rate
   ___ Primary C-section rate
   ___ C-section rate for nulliparous term singleton vertex (NTSV) pregnancies
   ___ Indication for C-section
   ___ Vaginal birth after Cesarean (VBAC) rate for women with prior C-sections
   ___ Trial of labor after Cesarean (TOLAC) rate
   ___ Newborn birth trauma
   ___ OB trauma (3rd or 4th degree lacerations) - vaginal with instrument
   ___ OB trauma (3rd or 4th degree lacerations) - vaginal without instrument
   ___ Incidence of episiotomy
   ___ Elective C-section/induction prior to 39 weeks gestation
   ___ Medical inductions prior to 39 weeks gestation
   ___ Elective inductions 39-41 weeks gestation
   ___ Indication for induction
   ___ Breastfeeding initiation
   ___ Exclusive breastmilk feeding during the hospital stay

4. Do you compare or report your data with any of the following regional and/or national benchmarking data (please check all that apply)?
   ___ JCAHO (The Joint Commission)
   ___ VON (Vermont Oxford Network)
   ___ The Leapfrog Group
   ___ NPIC (National Perinatal Information Center)
   ___ OB COAP (Obstetrics Clinical Outcomes Assessment Program)
   ___ WSPC/WSHA (Washington State Perinatal Collaborative/Washington State Hospital Association)
   ___ Other, please describe: _____

5. Do you track data by provider?

___ Yes, for all indicators tracked

___ Yes, for selected indicators tracked, please specify: _____

___ No (please go to question 7)

6. How often do you share provider-specific data with providers?

___ Data aren't shared with providers

___ Yearly

___ Quarterly

___ Other, please describe: _____

7. Did your hospital participate in the statewide initiative to reduce Early Elective Delivery before 39 weeks gestational age?

___ Yes

___ No (please go to question 9)

8. What best describes your current hospital policy regarding induction of labor or scheduling of Cesarean section (C/S) prior to 39 weeks when there is not medical indication? (Please check ONE answer and fill in "other" if needed)

___ No inductions or C/S prior to 39 weeks unless case has condition on the Joint Commission exclusion list, enforced by hospital staff (sometimes referred to as a hard stop)

___ Same as above with exception clause allowing for appeal to medical director or chief of department prior to delivery

___ No elective induction or C/S prior to 39 weeks allowed by policy, but provider may override policy and perform - all exceptions go to Peer Review after delivery

___ Elective induction or C/S prior to 39 weeks allowed at provider discretion, but discouraged by intensive education

___ Other, please explain: _____

9. Have there been any other obstetric quality initiatives in he past two years at your hospital?

___ Yes

___ No

If yes, please describe: _____

10. Do you anticipate any obstetric quality initiatives in the year to come?

___ Yes

___ No

If yes, please describe: _____

## Section 2: Labor Admission

The next few questions address your hospital's policies and practices related to admitting women in labor.

11. How does your hospital establish an admitted woman's gestational age?

___ Record what admitting provider reports

___ Record what admitting provider reports and note source of information

___ Establish gestational age using standard protocol

12. Does your hospital have a written policy or protocol for delaying admission of low risk women who present in prodromal labor?

___ Yes

___ No (please go to question 15)

Comments: _____

13. Does this policy include specific criteria to distinguish prodromal labor from active labor?

___ Yes

___ No (please go to question 15)

What are the criteria: _____

14. If a woman does not meet the active labor criteria, is she:

___ Sent home by hospital staff

___ Not admitted, but allowed to labor in a designated area of the hospital until she meets criteria

___ Admitted to hospital for observation (not admitted to labor and delivery)

___ Admitted to hospital labor and delivery only after provider call and consults with appropriate chain of command, e.g. Obstetric Medical Director

___ Admitted to hospital labor and delivery and chart is sent for peer review of exception to policy

___ Other, please explain: _____

15. Please check the items below that would justify admitting a woman in prodromal labor at your hospital (please check all that apply):

___ Residence is a significant distance from hospital

___ Provider preference

___ Medico-legal issues

___ Extenuating circumstances (e.g. husband is about to be deployed)

16. Does your hospital have a lounge or place where women in early labor can rest and wait to see if they progress to active stage?

___ Yes (please go to question 18)

___ No

17. What are the barriers to providing a place for women in early labor (please check all that apply)?

___ No space available
___ Cost
___ Staffing
___ Liability
___ Other, please describe: _____

## Section 3: Labor Management

The next few questions address your hospital's policies and practices related to labor management.

18. Does your hospital have a written policy regarding fetal monitoring in low-risk women?

___ Yes
___ No

19. What is your hospital's policy or normal practice regarding fetal monitoring in low-risk women?

___ Most low risk women have continuous fetal monitoring
___ Most low risk women have intermittent auscultation
___ Other, please describe: _____

20. Does your hospital use central fetal monitoring?

___ Yes
___ No

21. Does your hospital have standard definitions of labor arrest for:

1st stage labor arrest
___ Yes, please define: _____
___ No

2nd stage labor arrest
___ Yes, please define: _____
___ No

22. Does your hospital require a documented second opinion for a Cesarean section due to a diagnosis of labor arrest?

___ Yes, by whom: _____
___ No

23. Does your hospital require a documented second opinion for a Cesarean section due to a diagnosis of fetal intolerance of labor?

___ Yes, by whom: _____
___ No

24. Approximately what percent of deliveries use doulas for one-on-one labor support/coaching at your hospital?

___ None
___ < 5%
___ 5-9%
___ ≥10%

25. What are the barriers to using doulas for one-on-one labor support/coaching at your hospital (please check all that apply)?

___ Patient cost
___ Hospital cost
___ Supervision/oversight
___ Patients haven't requested doulas
___ Nursing staff don't support doulas
___ Variation in doula training
___ Variation in doula ability to work as part of labor and delivery team

26. How often are nurses at your hospital able to provide one-on-one labor support/coaching during active labor?

___ Almost always (please go to question 28)
___ Sometimes (please go to question 28)
___ Never

27. What are the barriers to nurses providing one-on-one labor support/coaching (check all that apply)?

___ Cost
___ Staffing
___ Patient load too high
___ Other, please specify: _____

28. Does your hospital provide women information or a form to complete a birth plan describing their labor and delivery preferences?

___ Yes
___ No

## Section 4: Induction of Labor

The following questions relate to your hospital's policy and practices around scheduled labor induction.

29. Who does the provider's office contact in order to schedule an induction of labor?

___ Labor and delivery nurse
___ Labor and delivery secretary/administrator
___ Obstetrics charge nurse
___ Other, please specify: _____

30. How far in advance can a provider schedule an induction of labor?

___ days OR ___ weeks OR ___ any time

31. Does your hospital have a written policy for scheduling an induction of labor?

___ Yes
___ No (please go to question 35)

32. Does your hospital policy for scheduling an induction of labor include:

___ Patient counseling using a written tool showing risks/benefits of induction (e.g. using a patient decision aid)
___ Specific criteria for scheduling induction of labor
___ Completion of an induction form/checklist which is filled out prior to admission (go to question 34)

33. Does the form/checklist include (check all that apply):

___ Gestational age
___ Method of determining estimated date of delivery
___ Gravidity/parity
___ Indications for induction
___ Bishop score
___ Method of induction
___ Estimated fetal weight
___ Fetal presentation
___ Group B Strep status
___ Induction consent form signed
___ Other, please specify: _____

34. If a woman does not meet the criteria for induction of labor, is the induction (please check ONE answer and fill in "other" if needed):

___ Not allowed by policy, with hospital staff as enforcers (sometimes referred to as a hard stop)
___ Same as above with exception clause allowing for appeal to medical director or chief of department prior to induction and delivery
___ Not scheduled by policy, but provider may override policy and perform - all exception go to Peer Review after delivery
___ Scheduled at provider discretion, but discouraged by intensive education
___ Other, please explain: _____

## Section 5: Scheduled Cesarean Section

The following questions relate to your hospital's policies and practices related to **scheduling** Cesarean sections.

35. Who does the provider's office contact in order to schedule a planned Cesarean section?

___ Operating Room scheduler
___ Labor and delivery nurse
___ Labor and delivery secretary/administrator
___ Obstetrics charge nurse
___ Other, please specify: _____

36. How far in advance can a provider schedule a Cesarean section?

___ days OR ___ weeks OR ___ any time

37. Does your hospital have a written policy for scheduling a Cesarean section?

___ Yes
___ No (please go to question 41)

38. Does your hospital policy for scheduling a Cesarean section include:

___ Patient counseling using a written tool showing risks/benefits of Cesarean section (e.g. using a patient decision aid)
___ Completion of informed consent form for Cesarean section
___ Specific criteria for scheduling Cesarean section
___ Completion of an induction form/checklist which is filled out prior to admission (go to question 40)

39. Does the scheduled Cesarean form/checklist include (check all that apply):

___ Gestational age
___ Method of determining estimated date of delivery
___ Gravidity/parity
___ Indications for scheduled Cesarean section
___ Consent form signed
___ Other, please specify: _____

40. If a woman does not meet the criteria for scheduling a Cesarean section, is the Cesarean section (please check ONE answer and fill in "other" if needed):

___ Not allowed by policy, with hospital staff as enforcers (sometimes referred to as a hard stop)
___ Same as above with exception clause allowing for appeal to medical director or chief of department prior to induction and delivery
___ Not scheduled by policy, but provider may override policy and perform - all exception go to Peer Review after delivery
___ Scheduled at provider discretion, but discouraged by intensive education
___ Other, please explain: _____

## Section 6: Vaginal Birth/Trial of Labor After Cesarean Section

The following questions relate to your hospital's policies and practices related to trial of labor after prior Cesarean section.

41. Does your hospital offer trial of labor after Cesarean deliveries (TOLAC)?

___ Yes
___ Not currently, but in planning stages to offer TOLAC (please go to question 45)
___ No (please go to question 45)

42. Does your hospital have a written policy which establishes criteria for attempting a trial of labor after previous Cesarean delivery?

___ Yes
___ No (please go to question 45)

43. Does your hospital policy for offering TOLAC include:

___ Patient counseling using a written tool showing risks/benefits of trial of labor after previous Cesarean section (e.g. using a patient decision aid)
___ Completion of informed consent form for trial of labor after Cesarean
___ Specific physician or staff requirements for performing TOLAC
___ Specific patient criteria for performing trial of labor after Cesarean
___ Completion of an induction form/checklist which is filled out prior to admission (go to question 45)

44. Does the trial of labor form/checklist include (check all that apply):

___ Gestational age
___ Method of determining estimated date of delivery
___ Gravidity/parity
___ Fetal presentation
___ History of uterine rupture
___ Number of prior Cesarean sections
___ Documentation of uterine scar
___ Prior VBAC
___ Prior vaginal birth
___ Indication for prior Cesarean section
___ Trial of labor consent form signed
___ Other, please specify: _____

## Section 7: Staffing and Training

The next several questions address types of providers in your labor and delivery service, as well as training and eduction of nursing staff.

45. Does your hospital employ Laborists (also called OB Hospitalists)?

___ Yes
___ No (please go to question 48)

46. What days are Laborists working on-site at your hospital?

___ 7 days a week
___ Monday-Friday only
___ Weekends only
___ Other, please specify: _____

47. What hours are Laborists working on-site at your hospital?

___ 24 hours a day
___ Daytime only
___ Nights only
___ Other, please specify: _____

48. Do Certified Nurse Midwives have delivery privileges at your hospital?

___ Yes
___ No (please go to question 50)

49. Approximately what percent of deliveries are attended by Certified Nurse Midwives at your hospital?

___ ≤ 5%
___ 6-10%
___ 11-15%
___ >15%

50. Does your hospital have a formal affiliation or Memorandum of Understanding with a birth center staffed by Licensed Midwives or Certified Nurse Midwives?

___ Yes
___ No

51. How do nurses at your hospital stay current on labor support techniques and approaches (check all that apply)?

___ In-person training offered on-site
___ Webinar organized by your hospital
___ Webinar organized by nursing experts, such as AWHONN, Certified Nurse Educator, UW School of Nursing
___ Other, please describe: _____

52. How often does your hospital require continuing education credits on labor support for your labor and delivery nurses?

___ Annually
___ Every other year
___ Every 5 years
___ No requirement
___ Other, please specify: _____

53. How often does your hospital offer on-site in-person training on labor support techniques and approaches?

___ Periodically, but less than yearly
___ Yearly
___ New staff orientation only
___ Don't offer on-site in-person training on labor support
___ Other, please specify: _____

54. How often does your hospital require continuing education credits on fetal heart rate tracing interpretation and description for your labor and delivery nurses?

___ Annually
___ Every other year
___ Every 5 years
___ No requirement
___ Other, please specify: _____

55. How often does your hospital offer on-site in-person training on fetal heart rate tracing interpretation and description?

___ Periodically, but less than yearly
___ Yearly
___ New staff orientation only
___ Don't offer on-site in-person training on fetal heart rate tracing
___ Other, please specify: _____

56. Does your hospital require training on using standard language to describe fetal heart rate tracing in labor?

___ Yes, we require training for labor and delivery nurses
___ Yes, we require documented training for provider delivery privileges
___ No, we do not require training

57. Does your hospital require training on standards for intermittent auscultation (check all that apply)?

___ Yes, we require training for labor and delivery nurses
___ Yes, we require documented training for provider delivery privileges
___ No, we do not require training

58. Do providers delivering at your hospital have a strong preference to attend the deliveries of their own patients?

___ Yes, most providers at our hospital prefer to deliver their own patients

___ Yes, some providers at our hospital prefer to deliver their own patients

___ No, providers at our hospital do not seem to have a strong preference

59. Earlier in the survey we asked several questions about a variety of hospital policies regarding labor and delivery management. At your facility, are there consequences for providers if these policies area not followed?

___ Yes

___ No

If yes, please describe briefly: _____

_____

_____

60. Are there materials or training the Washington State Perinatal Collaborative could provide which would help you improve the efficacy, safety and quality of obstetric care at your hospital?

___ Yes

___ No

If yes, please elaborate: _____

_____

_____

61. Is there anything we may have overlooked? If you have additional comments regarding perinatal practices or this survey that you would like to provide, please note them below.

_____

_____

_____

Thank you very much for completing this survey!

If you would like to share your experiences using this toolkit, success stories, or other feedback, please send an email to centerebp@ohsu.edu.

Washington State Health Care Authority

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